NHS

National Treatment Agency
for Substance Misuse

DIP Engagement Tool-Kit

February 2009

CONTENTS

INTRODUCTION

AIMS AND SCOPE

This toolkit forms part of an approach to help partnerships problem-solve issues relating to DIP referrals engaging into treatment. The aim of this toolkit is to provide support across four areas:

- Support regional managers in **understanding and interpreting the treatment engagement figures** for local DIP teams as reported in the Quarterly DIP Performance Report

- Provide a reference point for **data analysts** to reproduce national DIP performance figures produced by the NTA. In other words, a "how to do" guide to help data analysts or information managers undertake a match between DIP and NDTMS data.

- A process check-list for **operational providers** to follow that will help provide a greater understanding of why there may be attrition in the reporting following a referral to specialist Tier 3 treatment. This will take four main scenarios – (1) what to do where there is no match to NDTMS; (2) what to do if a client referred is recorded as already in treatment; (3) what to do if a referral results in a triage at a treatment service some time (for example, 6 weeks) after initial referral and (4) what to do if a NDTMS triage occurs before a DIP referral

- A **case-file check list** for any relevant stakeholder (such as a Deputy Regional Manager) to provide a more in-depth qualitative understanding as to the efficacy of referral processes; recording of information; and general file management. This may be appropriate if data matching between DIP and NDTMS is not available

BACKGROUND

This document is in response to the findings from a study *DIP Treatment Engagement* that provided an assessment as to the reasons behind the wide range of treatment engagement rates following a DIP referral. Six findings from this study were highlighted:

- National matching processes could be closely replicated in local DAAT areas

- Three critical-to-quality (CTQ) issues were identified (1) **attributers** (initials, date of birth and gender); (2) **recording of appropriate referrals** and (3) the impact of drug misusers **already in treatment**. The impact of these CTQ items was estimated to be 17% nationally

- The impact of Tier 2 interventions whereby a referral to a lower threshold service was inappropriately recorded. For example, a referral to a Tier 2 service was sometimes recorded as a "new" referral to a Tier 3 agency.

- Client characteristics such as primary drug of choice did not explain why a referral did not subsequently engage with treatment. Rather the study found that inappropriate completion of the DIR and AF was more likely to result in a misalignment between figures

- Communication and intended consequences highlighted how communication across the "whole system" of DIP may not have filtered to operational teams

- There was an impact of referrals that were subsequently remanded within prison. This was estimated to have represented 10-12% of all referrals

INTERPRETING DIP DATA

BACKGROUND

The *Quarterly DIP Performance Report* summarises partnership performance in relation to the referral of **DIP clients into structured treatment** via CJITs and their subsequent engagement with treatment. The data sources for this report are the Drug Interventions record (DIR) and associated CJIT Activity Form (AF) and the National Drug Treatment Monitoring System (NDTMS).

The Quarterly DIP Performance Report covers the latest 3-month period where DIR / AF final data are available. The first report published in the current format covered the period March to May 2008 (the quarters reported are not financial because the schedule has been designed to fit into the quarterly partnership review process.) Performance figures are reported at partnership level for all intensive and non-intensive DIP areas, regional-level and national.

The performance areas considered as part of the NTA quarterly reviews from 2008/09 onwards focus on the initial care pathway and the process by which offenders identified as requiring structured drug treatment interventions are referred, assessed and enter appropriate services. As part of the needs assessment process, partnerships should have identified what proportion of those with an agreed care plan should be referred to specialist treatment by the CJIT. Subsequently partnership performance should consider the proportion of those referrals that receive a triage assessment following referral, and what proportion of those triaged then start a structured drug treatment intervention.

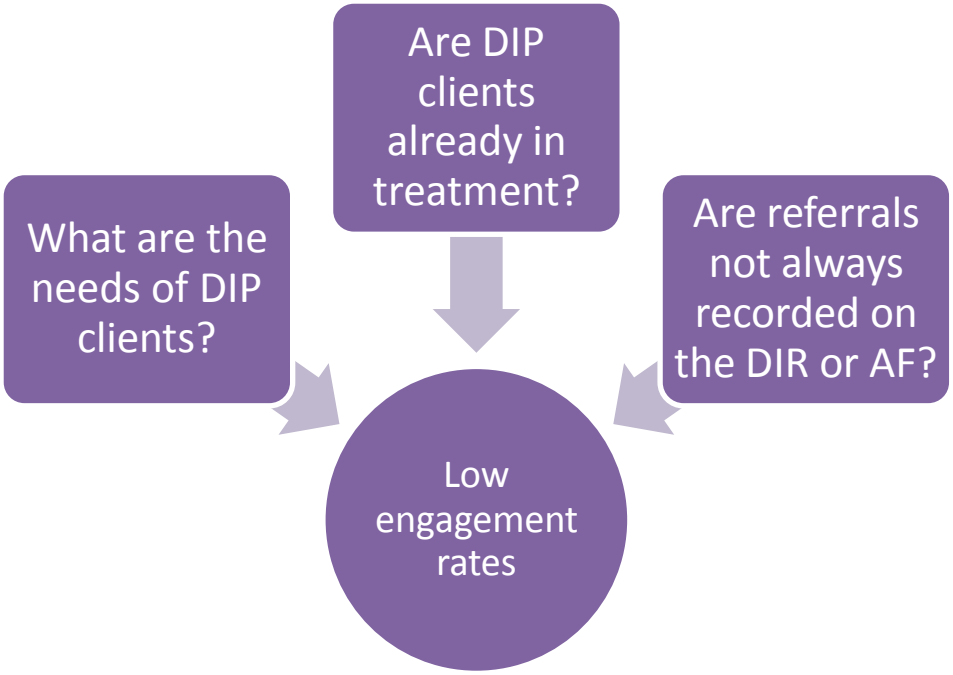
DIP CARE PLANS AND REFERRALS

The first section of the report focuses on care planning and treatment. The spreadsheet shows the number of DIP clients who agreed a care plan with the local CJIT in the quarter. It also shows the number of these clients that were subsequently referred to structured treatment (where the referral/s were made within 28 days of the care plan being agreed with the client), and the proportion (%) that this represents of all clients who agreed a care plan in the quarter.

This information is an aggregation, across the quarter, of the monthly care plan and referrals data on the DIP Dashboards produced by the Home Office – the data source for this information is the DIR and Activity Form and the figures have been calculated as described in the analytical specification for the DIP Dashboards (available on the DIRWeb Help Page).

The proportion (%) of clients taken onto the CJIT caseload (i.e. agreeing a care plan) who should be referred into structured drug treatment will depend on local treatment need. Whilst it is recognised that there is no ideal proportion, it is expected that the majority of clients agreeing a DIP care plan have a treatment need and should be referred into structured treatment if they are not already actively engaging in treatment. If the proportion of clients referred following care plan is low – there are three questions to ask as shown overleaf in Figure 1:

Figure 1: Questions to consider when presented with low treatment engagement rates



- Is a low level of referral into structured treatment via DIP an accurate reflection of treatment need for this client group? Have services been commissioned to meet the need of local DIP clients? e.g. Is there a high incidence of recreational powder cocaine use which does not require a structured treatment response or local services are not providing for an adequate response to powder cocaine users with a treatment need?
- Many local offenders eligible for DIP are already in structured treatment - if so, why are they reappearing in custody? Are they engaging effectively? Is the treatment provider being made aware of their re-offending, and is the CJIT case manager initiating a review with the treatment provider?
- Not all referrals made to structured drug treatment (even if delivered within CJIT) are being recorded on the DIR or Activity Form - what steps are being taken to address this to give a more accurate picture of treatment need?

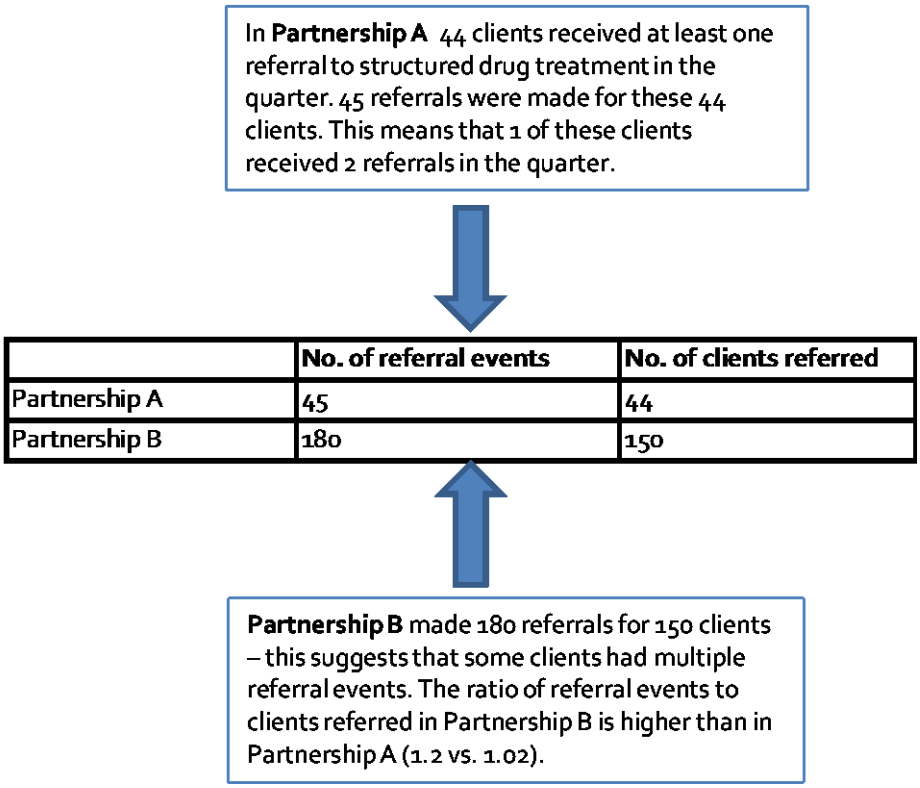
REFERRALS AND TREATMENT UPTAKE

REFERRALS

The treatment section of the report shows the total number of referrals made to structured treatment in the quarter (as recorded on DIRs and Activity Forms[1]) for clients on the CJIT caseload[2] and how many clients this relates to. An example of comparisons between Partnerships is shown overleaf in Figure 2.

[1] *Recorded under DIR 9.4 or Activity Form 3.5, 5.3 or 6.4*
[2] *Regardless of when the client's care plan was agreed.*

FIGURE 2: A worked comparison between Partnership referrals



A client may have **more than one referral** to structured treatment in a quarter if:

- The client was referred to more than one treatment provider receiving different treatment interventions - prescribing offered by one service and structured day-programmes by another.
- The client was referred to a treatment provider after agreeing a care plan with DIP but dropped-out and did not engage with the treatment provider. Following re-arrest and assessment by DIP within the same quarter the client agreed a new care plan and was subsequently re-referred to treatment.

If the ratio of referral events to clients referred is **high** this could indicate:

- Clients being referred to multiple services as described above – are local services provided to DIP clients in this way?
- Clients are disengaging after care plan but then re-engaging with DIP shortly after, e.g. following re-arrest, therefore more than one care plan and referral is agreed with a client in the same quarter – is there an issue with engagement locally? What can be done to improve this?
- Referrals made by the CJIT to structured treatment are being over recorded on the DIR and Activity Forms. For example:

  A. More than one Activity Form is being completed to record one referral event, or the one referral event is being recorded on the DIR as well as on the Activity Form – a local audit of the paper forms and records held on the IT system should highlight if the same referral events are recorded more than once.

B. CJIT workers are recording any contact made with treatment providers as a "referral event", e.g. the original referral is captured on the relevant form but forms are also being completed to record any follow-up phone calls made to the provider to check that the client has engaged – an audit of the forms and records held on the IT system against case notes would identify where this is happening. Only the actual referral to start a new treatment episode needs to be recorded on the DIR / Activity Form.

TREATMENT UPTAKE

By matching DIP data to NDTMS the report shows the number clients who were referred into structured treatment via DIP, as described above, broken down into those individuals who were:

- triaged by a structured treatment provider within 6 weeks of referral by DIP[3]; **(Columns c-e in Quarterly reports)**
- triaged after 6 weeks; **(Columns h-i)**
- entered into structured treatment following referral by DIP but were already in structured treatment at the time (with the same or other provider); **(Columns j-k)**
- not in any of the three categories above but have previously been in structured treatment according to NDTMS records since April 2004; and **(Columns l-m)**
- recorded with no treatment record on NDTMS since April 2004, i.e. no treatment engagement following the DIP referral and no treatment history. **(Columns n-o)**

In addition, the report also shows the number of clients starting a modality following triage within 6 weeks of DIP referral **(Column f).** Figure 3 below presents treatment uptake figures for two fictional partnerships. For both partnerships less than one-third of clients referred into structured treatment by DIP were triaged by a treatment provider within 6 weeks of referral.

FIGURE 3: Example of Treatment Uptake figures[3]

	Partnership A		Partnership B	
Clients Referred	**110**		**35**	
No. Triaged within 6 weeks (C-E)	**30**	**27%**	**10**	**29%**
No. Triaged after 6 weeks (H-I)	**10**	**9%**	**0**	**0%**
No. Already in treatment (J-K)	**35**	32%	**3**	**9%**
No. Previously in treatment (L-M)	**5**	**5%**	**20**	57%
No. With no treatment record (N-O)	**30**	27%	**2**	6%
TOTAL	110	100%	35	100%

In Partnership B almost 60% of clients referred by DIP had an open treatment episode and only two clients had no treatment match. In other words, the figures suggest that almost all clients referred by DIP in Partnership B either entered treatment following DIP referral or whether already engaged with treatment services at some point.

In Partnership A almost one-third (32%) of clients referred had an open treatment episode on NDTMS (already in treatment), and over a quarter (27%) have no treatment record on NDTMS.

[3] *The NDTMS extract that is matched to a particular quarter's w*
orth of DIP referrals includes treatment records up to the end of the month following the quarter (i.e. NDTMS up to September is matched to DIP referrals made in June-August), therefore any clients who entered treatment following referral by DIP but outside of the period covered by the NDTMS extract will not count here, e.g. a DIP client referred to structured treatment in late August and entering treatment in October will be counted in the referral figures in June to August 2008 but not in the figures for clients triaged following referral because the treatment episode is outside of the matching timeframes.

The relatively **low performance** for Partnerships A and B should start to trigger a series of questions. Questions for partnership A and B might be:

Partnership A:

Q1. What happened to the 30 clients who did not appear on NDTMS at all? The first step is to identify the clients concerned and then use the **audit checklist** and **tracking/matching tools** to establish the reason that they are not recorded as engaging in treatment on NDTMS. This will require the CJIT and treatment providers to work together and compare records. In broad terms, the reasons will either be data collection errors (e.g. inaccurate attributors, referral dates etc), inaccurate information (e.g. not referred to structured treatment) or simply that the client failed to engage in treatment.

Q2. If these enquiries establish that the reason that the client is not recorded on NDTMS is that they failed to attend the triage assessment with the treatment provider it will be necessary to check whether they are still on the DIP caseload and if so what is being done to re-engage them in treatment. If they are no longer on the DIP caseload, what is the CJIT doing to re-engage them?

Q3. If tracking work undertaken between the CJIT and treatment provider indicates that the 30 client/s are engaging in treatment then why are they not appearing on NDTMS? Is the provider submitting client records correctly to NDTMS?

Q4. 32% of clients referred were already in treatment – was the CJIT aware that the clients were already in treatment? If yes, why was a new referral to treatment recorded? Was the referral made to a different provider? Are the clients actively engaging in treatment as suggested by an open NDTMS episode? Or should some of the "open" episodes have been closed off by the provider - client disengaged / gone into custody etc?

Partnership B:

Q5. 57% of clients referred were already in treatment – was the CJIT aware that the clients were already in treatment? If yes, why was a new referral to treatment recorded? Are the clients actively engaging in treatment as suggested by an open NDTMS episode? Or should some of the "open" episodes have been closed off by the provider - client disengaged / gone into custody etc? If a proportionately high number of clients coming through DIP are already in treatment are clients still re-offending?

DATA MATCHING

This section aims at providing an overview of what processes are required locally to match DIP data to NDTMS in order to replicate the national performance measures and to problem-solve high attrition rates. This section assumes that a representative or organisation has access to both datasets. We strongly suggest that there is a data-sharing protocol that can facilitate the exchange of information and that any individual undertaking the matching process is appropriately cleared and authorised to undertake this work. There are three stages to the matching process:

1. Derivation of a Drug Intervention Record for each individual

This creates a new dataset that links a Drug Intervention Record (DIR) with an Activity Form (AF) to an individual offender. Therefore, there is one record per individual. The *first referral* (either derived from the DIR or AF) is used to denote the primary referral. The exact method to link the data items is out of scope for this toolkit but can be achieved through the individual attributers (linking initials, date of birth and gender) which act as a unique record.

2. Creation of a NDTMS data file

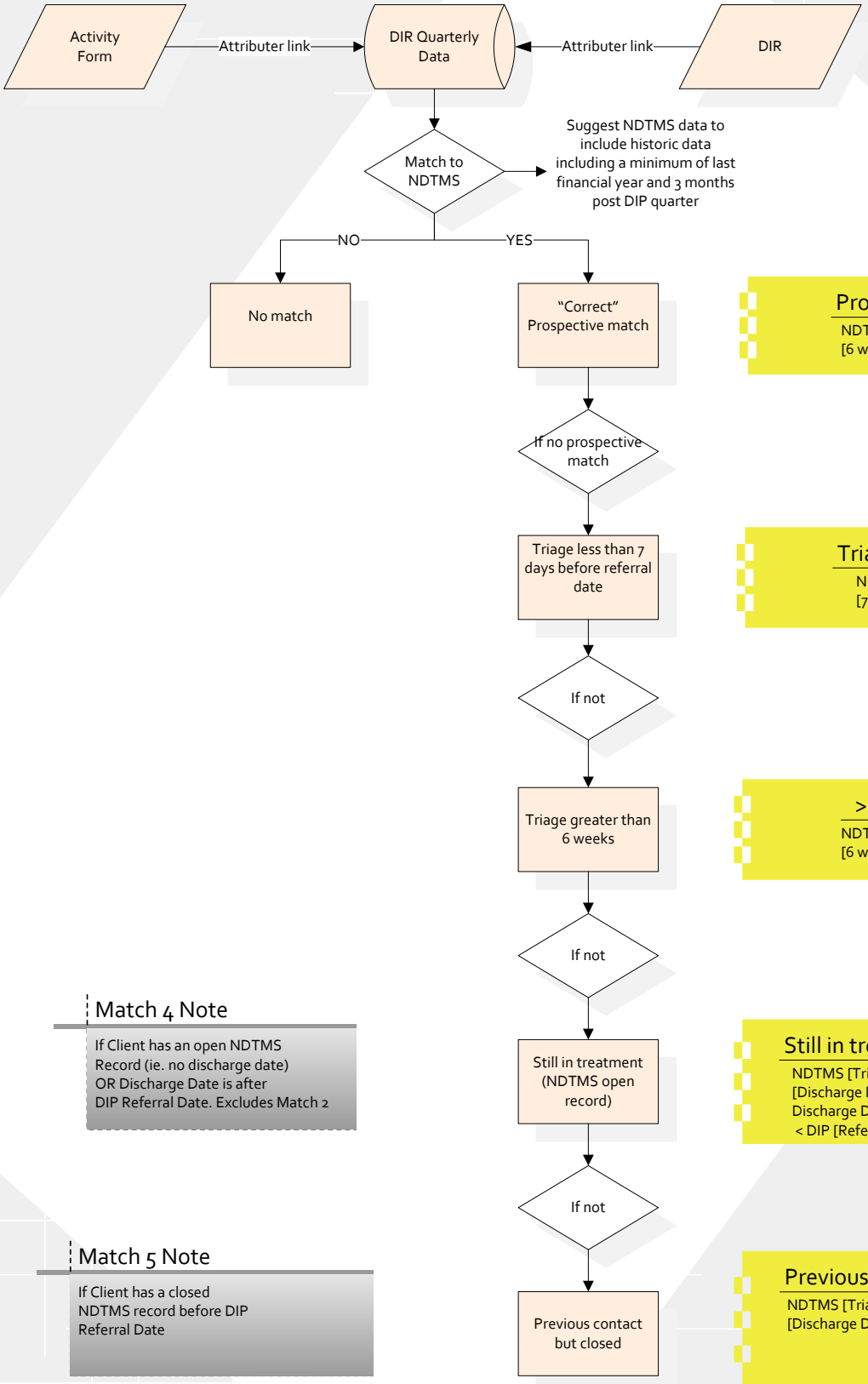
This component suggests that there should be a NDTMS dataset of unique individuals of the last financial year plus an additional 3 months after the DIP quarter being examined. For example, if the analyst was attempting to examine attrition between October and December in 2008, we recommend that NDTMS data from April 2008 to March 2009 be used for matching.

3. Matching rules DIP to NDTMS

Presented overleaf are a series of matching "rules" or procedures that helps derive a series of potential scenarios that may explain attrition rates to identify clear matches; matches where the dates are inverted (for example, when the date of NDTMS triage is before date of DIP referral); a match after 6 weeks; clients that are still in treatment and whether an individual has had a previous treatment episode in the last year.

An example of how to present the matching scenarios is included in the appendix.

DIP – NDTMS Data Matching Process



Prospective Match 1
NDTMS [Triage Date] >= [6 weeks] DIP [Referral Date]

Triage Date Match 2
NDTMS [Triage Date] < [7 days] DIP [Referral Date]

> 6 weeks Match 3
NDTMS [Triage Date] > [6 weeks] DIP [Referral Date]

Still in treatment Match 4
NDTMS [Triage Date] AND NDTMS [Discharge Date IS NULL OR Discharge Date > DIP [Referral Date] < DIP [Referral Date]

Previous episode Match 5
NDTMS [Triage Date] AND NDTMS [Discharge Date < DIP [Referral Date]

Match 4 Note
If Client has an open NDTMS Record (ie. no discharge date) OR Discharge Date is after DIP Referral Date. Excludes Match 2

Match 5 Note
If Client has a closed NDTMS record before DIP Referral Date

PROCESS TO TRACK MATCHES

These *scenarios* are derived from the section which looked at matching DIP data to NDTMS and aims to provide a series of processes to track individual offenders that may not have matched to NDTMS. Although good practice suggests that this should be achieved through use of a statistical match from DIP to NDTMS, there is no reason why partnerships should not use this process manually – that is, tracking clients through audits of paper-based files. Four scenarios are presented and are shown overleaf as a series of flowcharts:

1. When there is no match to NDTMS

This process tracks individuals that have not matched to NDTMS following a DIP referral. In particular, this approach suggests liaising with the service provider to check whether there has been contact and if the appropriate NDTMS records have been completed; or whether there are other extenuating circumstances such as the offender being remanded.

2. When a client is already in treatment

The study *DIP Treatment Engagement* suggested that this could happen in a number of ways – for example, DIP workers referring an offender *back into* treatment following a relapse or when an individual has not disclosed that they are already receiving treatment elsewhere. The impact of a client already in treatment resulting from "new" referrals is that it will not be included in the treatment uptake figures – rather they would appear as "already in treatment". That is, they would be counted within the treatment figures at the time of referral not because of the specific referral event recorded.

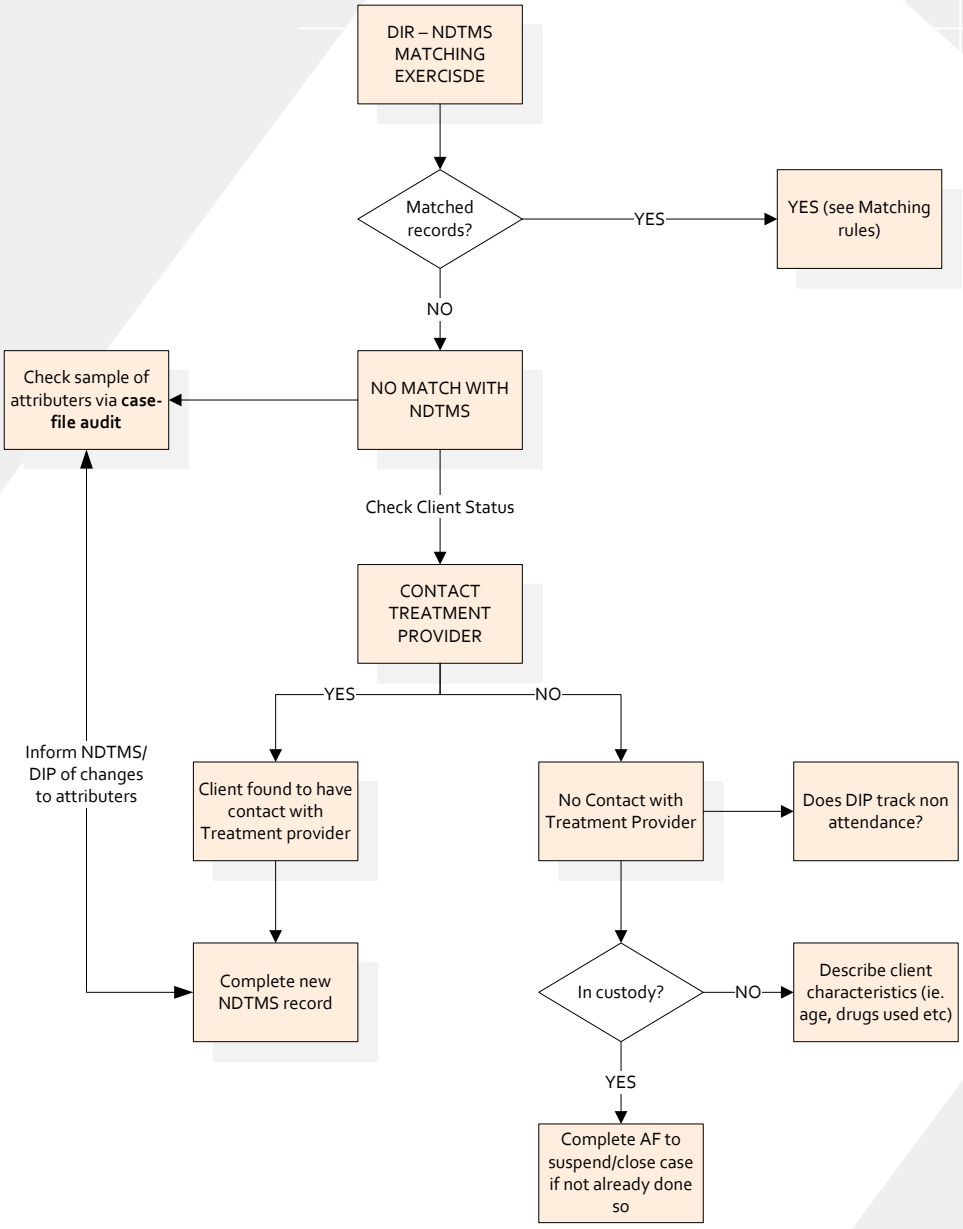
3. When a client accesses treatment after a period of 6 weeks

The research suggested that there were a number of instances when an individual accessed treatment over one month following referral. These included times when an offender has been in contact with the criminal justice system which has prevented immediate engagement with treatment, or when it has taken time to enhance an individual's motivation to seek treatment. This can be seen as important as offenders that take longer than 6 weeks to enter treatment may not be recorded within the performance monitoring reporting as they fall outside of the reporting timescales.

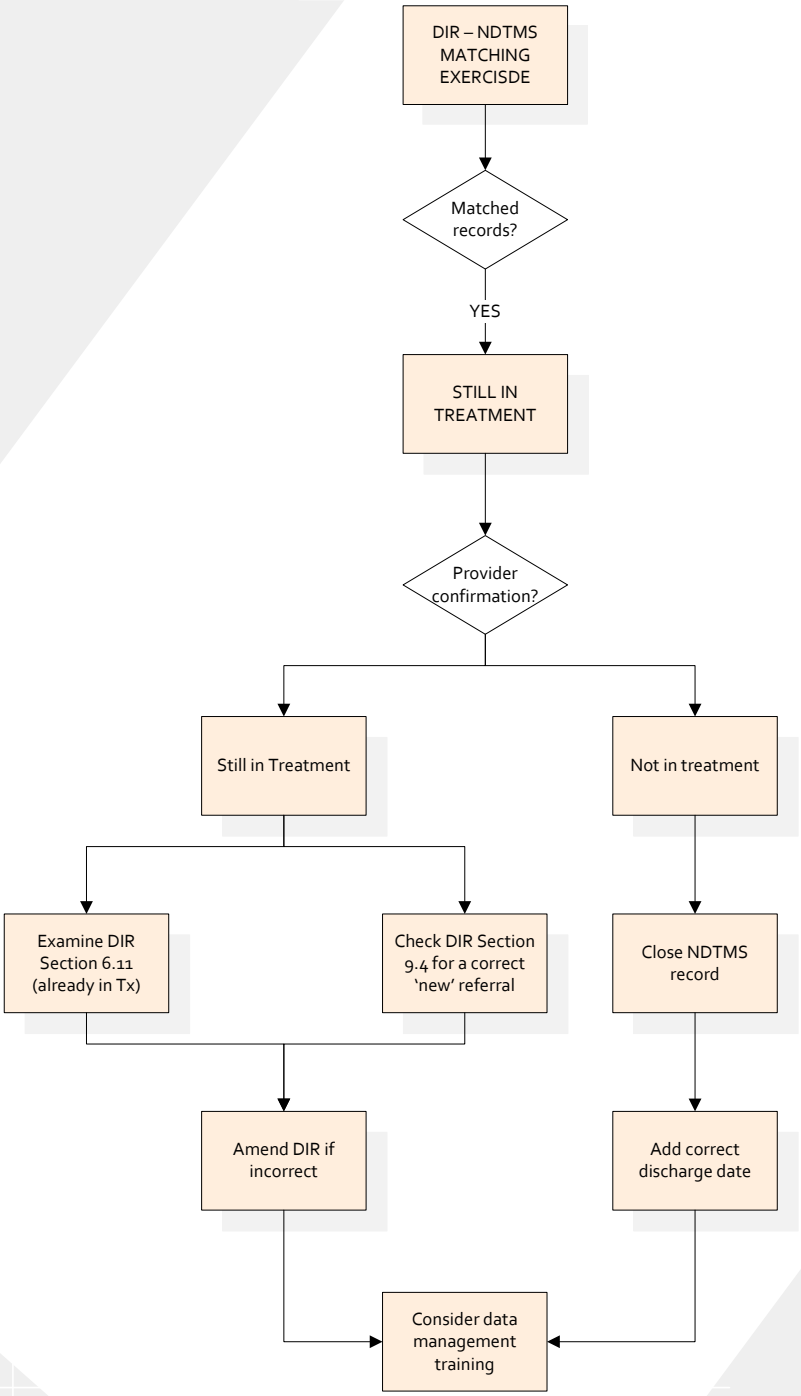
4. When a client is shown on NDTMS as triaged just before a DIP referral

Although this may seem counter-intuitive, this scenario occurs in a number of occasions. For example, for some integrated services (that is, agencies that provide both DIP and Tier 3 interventions), the date a care plan started within DIP became the *de facto* triage date for NDTMS, and this date fell before the referral date and therefore was not seen as a prospective match . This tends to occur when there is an integrated service and DIP/NDTMS processes have not been thoroughly delineated.

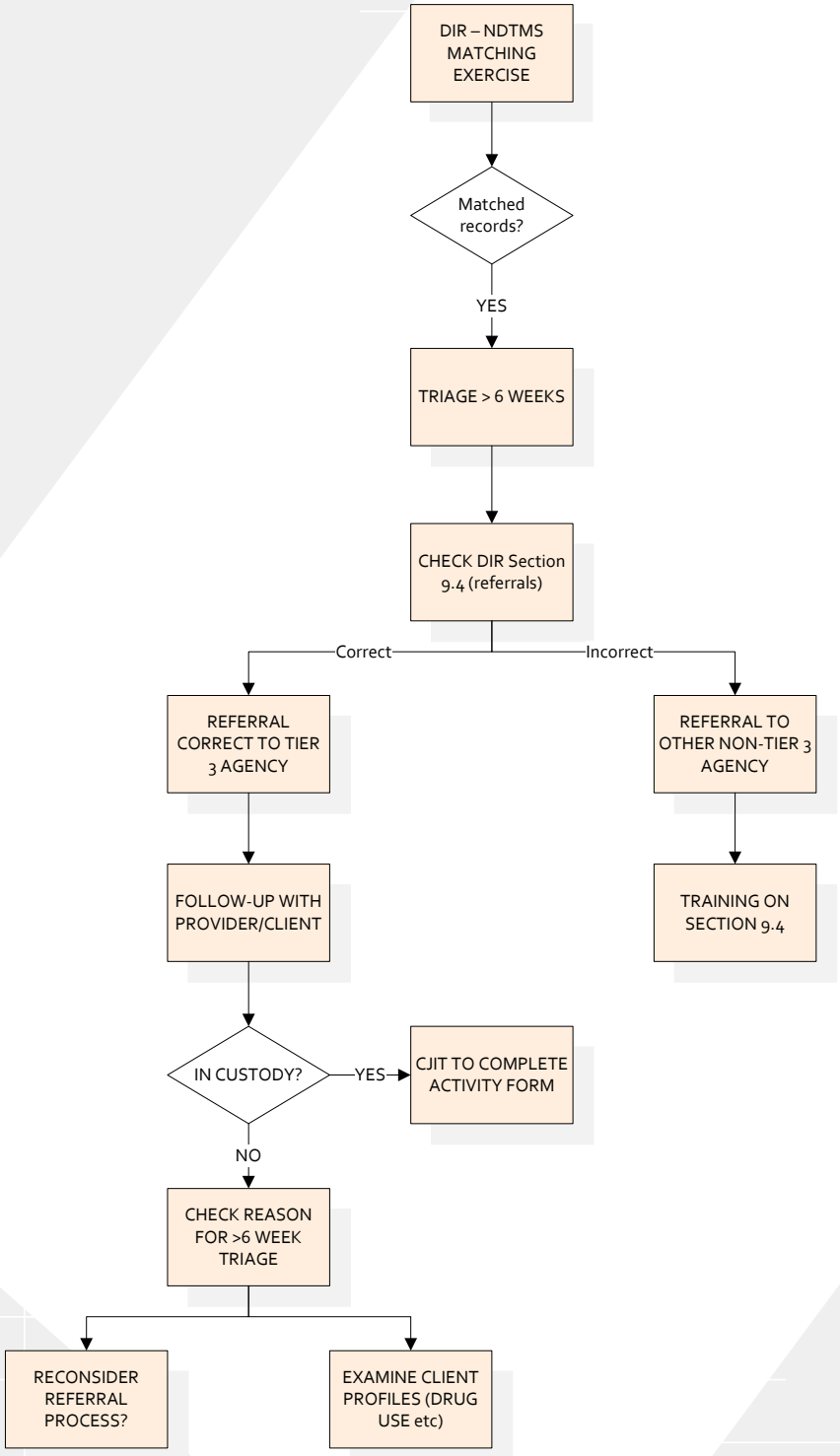
Process to identify matching issues: No NDTMS match



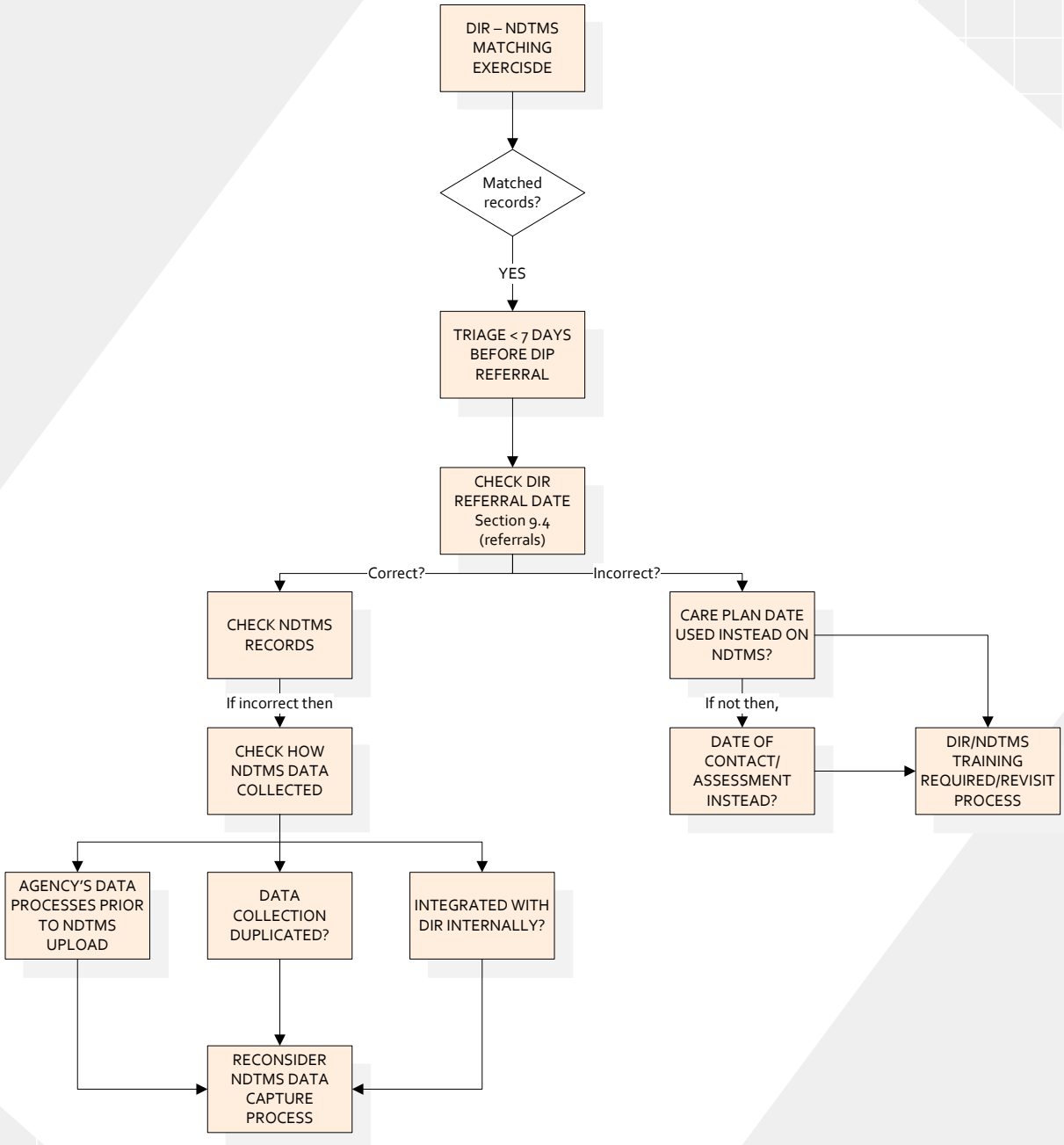
Process to identify Matching Issues: Already in Treatment



Process to identify Matching Issues: Triages > 6 weeks



Process to identify Matching Issues: NDTMS triage before DIP referral



CASE-FILE AUDIT

It may not be possible to routinely match datasets between DIP and NDTMS. This approach has assumed that there is access to both datasets and that resource is available to undertake an analytical and technical match. Also, a case-file audit provides stakeholders and commissioners of services with qualitative depth to understand local care planning and file management systems or processes. An audit alongside statistical analysis can provide the range of problem-solving techniques to understand the key operational issues within each DAAT area. Moreover, this depth can provide additional understanding of why an offender may not engage with services following a referral.

The approach to an audit would be to take a random sample of DIP files – around 10% is a typical size - and examine the file contents in relation to the themes covered in the audit.

Overleaf is an example of the type of questions that an audit of would aim to cover. The areas of good practice covered include:

- Client consent
- Care coordination including care planning clearly described
- Quality of case management
- Compliance with DANOS and Models of Care
- File management
- Manual tracking of DIP files to NDTMS

The case-file checklist is not meant to be comprehensive, rather a tool that can be adapted for local use and may reflect changing priorities or particular areas of interest.

Case File Checklist

1. Has the client's consent been signed?	YES	☐	NO	☐
2. Is there a clear care co-ordination log (ie. phone calls etc)?	YES	☐	NO	☐
3. Is the client's name clearly written?	YES	☐	NO	☐
4. Is the date of birth clear and not in error (ie. today's date)	YES	☐	NO	☐
5. Is the address clear on the client record?	YES	☐	NO	☐
6. Is there a named key worker on the case file?	YES	☐	NO	☐
7. Is there an initial care plan recorded on the case file?	YES	☐	NO	☐
8. Has a Tier 3 care plan (MoC/DANOS standards) completed?	YES	☐	NO	☐
9. Has a relevant TOP form been completed?	YES	☐	NO	☐
10. Are there regular and clearly recorded care plan reviews?	YES	☐	NO	☐
11. Is the referral to a Tier 3 service (for example, on S9.4 of the DIR)?	YES	☐	NO	☐
12. If YES to Q11., did the client attend the Tier 3 agency?	YES	☐	NO	☐
13. If the client did not attend the Tier 3 agency, why not (describe)?				
14. Does the service offer an integrated DIP and Tier 3 service?	YES	☐	NO	☐
If YES, Please go to Q15. below				
15. Can you track this client to their NDTMS record?	YES	☐	NO	☐
16. If NO, please describe why not?				